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Mister Chairman, members of the committee, for the record my name is Bill Baylor with Emdeon. I am testifying in support of HB 5069 – AA Reducing Health Care Fraud, Waste, and Abuse

- Emdeon is the nation's largest healthcare data exchange,
  - Processing 6B administrative, financial and clinical transactions annually
  - 90%+ of all providers,
  - 600 system vendors and
  - 1,200 public- and private-sector payers in the country,
  - Including Connecticut Medicaid where currently we submit and process over 1.8 Million Medicaid Claims and we connect to approximately 5,100 Providers and process over 18 Million of their claims annually
  - We also support a variety of products & services with virtually all commercial payers in the State, including but not limited to Aetna, BCBS of CT, ConnectiCare, Golden Rule, etc.

According to Centers for Medicare and Medicaid Services (CMS), Medicare paid more than $430 billion in medical claims for beneficiaries in 2009, but more than 10% of that or $45 billion was due to improper payments resulting from fraud, waste and abuse. Likewise, State Medicaid programs paid over $381 billion in medical claims for 51 million recipients in 2009, with nearly 5% or $18 billion attributed to fraud, waste and abuse.

As our nation faces nearly $14 trillion in national debt, it is unacceptable to throw always billions of taxpayers' dollars each year due to fraud, waste and abuse aimed at the critical healthcare programs.

Medicaid expenditures for fraudulent claims cost states billion of dollars each year. In Florida Medicaid fraud accounts for between 5 and 20 percent of the Medicaid Budget. Fraud and abuse account for between 3- 10 percent of the Medicaid Budget nationwide and yet the average state recovery rate is only .09 percent ; the recovery range among states is from less than .01 percent to a little more than 1 percent.

Approximately 72 percent of healthcare fraud is committed by medical providers (i.e. health professional, facilities, and service equipment and prescription drug suppliers) 10 percent by consumers and the balance by others including insures and their employees

Examples of healthcare fraud and abuse are A. (Medical service providers) 1.Billing for services not preformed; 2. Billing duplicate times for the same service; 3. Falsifying a diagnosis; 4. Billing for more costly a service than performed. 5. Ordering excessive and inappropriate test B.2. To medical identity theft (patients and providers) C .to systematic denial and underpayment of claims (insurance companies)

Evidence shows that concerted state anti-fraud and abuse efforts save states millions and in some cases billions of dollars each year and states could even double or triple current collections. It appears from the more the anti –fraud tools a state has at its disposal, the greater the likelihood of fewer unwanted payments and larger recoveries. The most effective tools for combating fraud have been- 1. State false claims act that include whistleblower protection; enhance staffing at state anti fraud agencies and, electronic data mining and predictive modeling systems

- The Connecticut Department of Social Services should be commended for their existing systems and programs to combat Fraud, Waste & Abuse.
    - Approximately 63% of enrollees are enrolled in a Managed Care Program
    - FFS Population is approximately 277,500
    - Code Edits – Embedded into the MMIS System
    - Post-Payment Review and Recoveries
    - Third Party Liability – Recoveries and Cost Avoidance
- Connecticut currently ranks:
    - 11th in fraud recoveries in 2011 with $46,256,031.95
    - 19th in fraud convictions with 9 and;
    - 34th for Medicaid fraud recovery rate for every federal dollar spent with $4.80
- However in an era of
    - budget constraints &
    - pending increases projected in Medicaid enrollment under the Affordable Care Act,
    - it has never been more important to utilize multiple, proven safety nets to increase ability to detect and prevent fraud, waste & abuse.
- The model legislation before you mirrors many provisions of Section 6028 of the Affordable Care Act that the State will have to comply with by 2014.
    - However, it goes further by:
        - Accelerating the timeline to achieving the savings
        - Changing the funding model to a full contingency based model
        - Providing a risked based claims scoring system in a Pre Pay Mode with a integrated case management system that builds the case and link analysis that connects various transactions and relationships between people and third parties.
        - Cross Payer Database where data is combine from multiple payer sources to provide a complete view of the potential Fraud, Waste and Abuse
- There are at least three very critical new tools to detect & prevent FWA included in this model legislation that can bring Connecticut Department of Social Services to a Best- in - FWA solution:
    - #1 Moving the decisions making up stream to prevention and detection away from pay and chase. Don't pay the claim unless you know its correct
    - #2 In-stream Provider Validation: The pre-adjudication in stream claim validation of deceased, retired, expired license, possible allegations of fraud and sanctioned providers, including provider sanction details and related professional background information, serves as an additional net to identify suspect claims and providers.

- #3 Pre-Pay Predictive modeling with an integrated case management system with link analysis:
  Simply put this system looks for fraud and scores the claims and the providers based on levels
  of aberrancy and risk. It uses a neural network as the basis for its predictive analytics, and
  "learns" as more data is fed into the system. Therefore, the aberrance, subtle nuances, and
  changes in the data are discovered, and the model changes as the data, as well as the fraud and
  abuse, changes. This allows for future claim lines and providers to be scored differently, based
  on the historical data and algorithms existing within the system. The data is fed into the case
  management system where the fraud investigators are able to see how the provider behaves
  when compared to his peers.
  - **Seeded Analytics with Cross Payer Data:** Emdeon has teamed with FICO, the predictive
    analytics organization which serves as the backbone of the credit card fraud detection
    industry, to develop and deploy a solution unparalleled in the healthcare industry. This
    powerful solution uses a combination of patented profiling technology, predictive models,
    statistical analysis and rules to achieve a level of detection accuracy that is unmatched. The
    analytics models are seeded with close to one billion Cross Payer claims from Emdeon. By
    pairing FICO's analytics models with Emdeon's proprietary analytics and claims experience,
    the team has created an unparalleled predictive analytics engine that is able to dig deeper
    into the data to find more potential savings.
  - **Link Analysis:** A link analysis engine finds connections between transactions, people, third
    parties and discrete fraud events that can reveal previously-hidden fraud schemes. The
    combined capabilities expand the view of the fraud investigator and enable the
    identification of more-complicated fraud patterns, criminal fraud rings, and networks of
    collusive participants that might otherwise appear disconnected from a fraud problem.
- These tools would also bring related benefits to the current state system and the new system, not the
  least of which include:
  - Reduce false positives
  - Faster compilation of case data
- National statistics for FWA savings range from ½ - 3% of total spend however the
  - Potential 2013 savings for CT Fee For Service Medicaid range from $10M - $21M per year
  - Potential 2014 savings for CT Fee For Service Medicaid range from $12M - $25 M per year
  - This would also significantly improve the number of fraud investigations and convictions as
    well a increase the recovery rate for every federal dollar spent
- These measure could help to pre-empt other, more drastic measures elsewhere to deal with budget
  constraints:
  - Reduction of benefits to beneficiaries
  - Reduction of provider reimbursement schedules...which negatively impact *all* providers, the
    vast majority of which are acting in good faith and providing quality care to those most in need.
- While there is no single magic bullet to eliminate FWA, adoption of the measures in this Bill will keep
  Connecticut Department of Social Services on the leading edge of this fight nationwide.
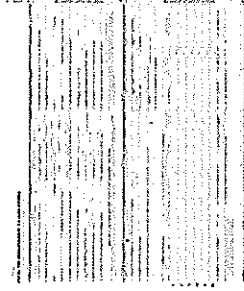
I would be happy to answer any questions you may have.

Provider Data Validation

- Expired and Sanctioned License
- Audit and unannounced site visits
- > 25% of Provider data changes each year
- Enrollment/Credentialing data verification
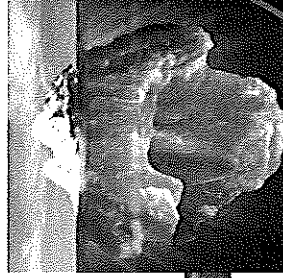
Clinical Integrity for Claims

- Mutually-exclusive edits
- Uncovers Bundling and Unbundled of procedure codes
- Correct Coding Initiative (CCI) Logic
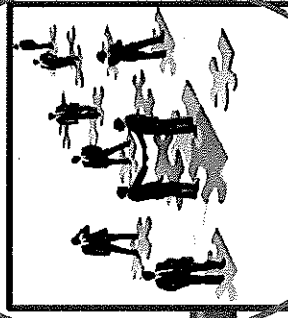- Custom edits

Fraud Detection Rules
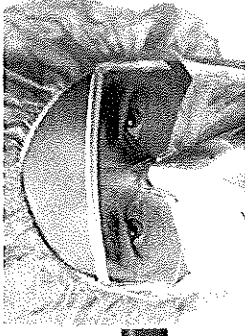
- Rules that flag known provider and claims schemes
- Clinically appropriate thresholds
- Specialty-specific

Predictive Analytics

- Known and unknown schemes
- Organized Fraud, new and emerging issues
- Complex Fraud and Abuse Patterns
- Data seeded with over 1 billion Emdeon cross payer claims

Link Analysis

- Matching and Relationship Intelligence
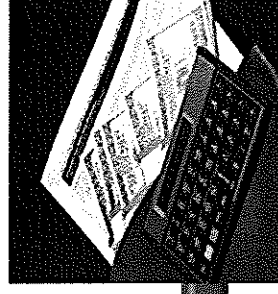- Identity match searches across disparate data sources
- Over 50 algorithms automate the matching and relationship process with extremely high precision
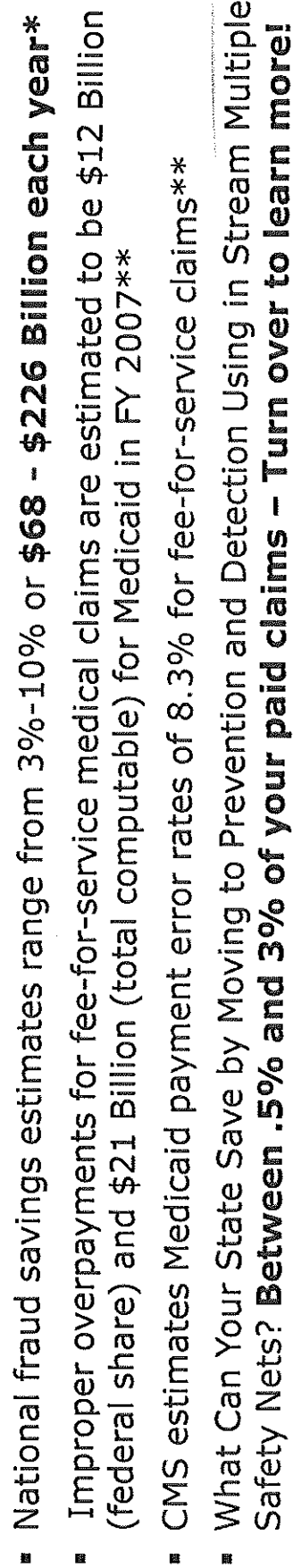
Investigations
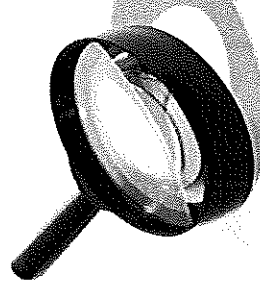
- Triage or full outsource
- Pend/pay/deny recommendations
- Request and review medical records

Recovery Audit Compliance

- Medical billing guidelines
- Contractual obligations
- Reimbursement rates and policies

Fraud Detections Positions

Move "upstream" for Prevention and Detection and away from Pay and Chase

Providers — **Emdeon** — **Payer**

Receive Claim → Adjudicate Claim → Pay Claim → Research, Recover

Position 1 (Optimal)

- Integrated in Adjudication
- Provider Verification
- Clinical Integrity for Claims
- Aberrancy Rules
- Predictive Modeling
- Data-Driven Analytics
- Investigations
- Third Party Liability

Position 2 (Optimal)

- Post-Adjudication Interface
- Provider Verification
- Clinical Integrity for Claims
- Aberrancy Rules
- Predictive Modeling
- Data-Driven Analytics
- Investigations

Position 3

- Post-Payment "Pay and Chase"
- Recovery Audit

- National fraud savings estimates range from 3%-10% or **$68 - $226 Billion each year***
- Improper overpayments for fee-for-service medical claims are estimated to be $12 Billion (federal share) and $21 Billion (total computable) for Medicaid in FY 2007**
- CMS estimates Medicaid payment error rates of 8.3% for fee-for-service claims**
- What Can Your State Save by Moving to Prevention and Detection Using in Stream Multiple Safety Nets? **Between .5% and 3% of your paid claims – Turn over to learn more!**

Emdeon Proprietary & Confidential See, for example, Health Care Anti-Fraud Association, (2009); The problem of health care fraud; Federal Bureau of Investigation, (2007), Financial crimes report to the public, Fiscal year 2007; PricewaterhouseCoopers' Health Research Institute (2008), The price of excess: identity waste in healthcare spending. **These estimates are taken from the FY 2007 Comprehensive Error Rate test (CERT) program for Medicaid

Pre-Payment Fraud Detection and its Impact on the Bottom Line

An ounce of prevention is worth a pound of cure.

Summary

The phrase, "An ounce of prevention is worth a pound of cure" aptly applies to a movement within the healthcare payment industry: Fraud, waste and abuse (FWA) prevention. Today, because of lean budgets and compelling cost analyses, payers are motivated to find solutions that can offer payment integrity by identifying FWA before they pay erroneous claims. However, to achieve true payment integrity, payers must consider adopting a proactive, preventive approach for optimal aberrance detection.

This paper intends to help payers determine the best ways to protect themselves against FWA. It demonstrates the benefits of proactive, in-stream claim review and illuminates powerful preventive resources, helping payers understand how to limit unnecessary claim payment, which could save them significant time and money.

In this Paper, You Will Learn:

- How shifting to a pre-adjudication or pre-payment fraud detection solution can yield significant financial impact
- Characteristics of an effective pre-payment FWA management solution
- Organization, system and process implications of adopting a pre-payment FWA management solution

An Emdeon and FICO

White Paper

emdeon

Simplifying the Business of Healthcare

Introduction

Recent estimates indicate three to ten percent of national healthcare spending is lost annually to abuse. The Patient Protection and Affordable Care Act, enacted in March 2010, brought about requirements and changes in federal law that directly and substantively addressed costly abuses.[1]

As a result, the payer community has collectively deemed FWA management solutions a top priority. In the past, payers often saw FWA solutions as legal and regulatory expenditures, but many now see them as an essential business initiative. To operate effectively, payers must respond to new laws directly, understanding that FWA programs can help them avoid significant costs and improve overall profitability.

Payers' Pain Points

Several factors influence a payer's business objectives and, when combined, can dramatically affect the bottom line:

- **The high cost of FWA.** The $68-$226 billion of healthcare dollars lost annually is an enormous blow to health insurance organizations—particularly when some of those dollars are lost trying to fight FWA with limited success.[2] Investing in a comprehensive payment integrity solution can help payers make significant progress in the fight against erroneous claim payments.

- **A constrained economy.** Economic factors are driving the need for more cost containment, forcing payers to prioritize resources based on their financial impact. Healthcare payers must address these issues head on to survive a highly competitive landscape. Because managing costs is imperative, many payers must determine where to reduce operational and medical expenses; a comprehensive FWA program may help reduce both.

- **High claims volume.** The sheer number of claims processed is daunting, creating a needle-in-a-haystack scenario for identifying FWA. Even with automation and safeguards, erroneous claims can go undetected, easily bypassing administrative edits in most claims adjudication systems.

- **Difficulty identifying FWA.** Many claims appear compliant initially, but when investigated, prove aberrant. These claims are innately difficult to identify, prove erroneous and resolve, and may include procedures that are:
  - Medically inappropriate
  - Beyond the scope of the provider's medical license
  - Billed but never performed

Scattered and Disjointed Payer Pain Points Drive Up Costs and Inefficiency

[1] *FBI Financial Crimes 2008, http://www.fbi.gov/stats-services/publications/fcs_report2008*

[2] *From The National Health Care Anti-Fraud Association (NHCAA),*
http://www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_centr&wpscode=TheProblemOfHCFraud
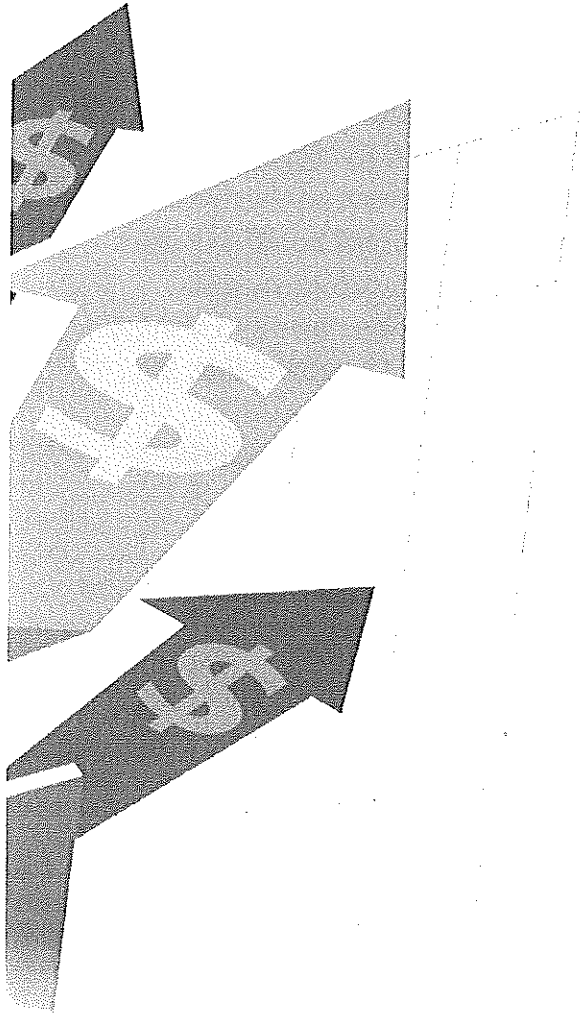
- **The enormous scope of FWA.** The scope of FWA is so large it overwhelms many commercial insurers' resources, which are not equipped to address the issue. While some payers staff special investigation units (SIUs), many lack the tools and resources necessary to combat FWA extensively or to their maximum benefit.

- **The prevalence of fraudsters.** Along with unscrupulous providers, organized crime rings steal patient identification and create fictitious services and procedures that not only defraud payers but also alter patients' medical histories permanently, endangering their health and safety. Perpetrators often elude detection and relocate before the fraud is uncovered. Some patients may commit fraud by allowing friends and family members who have little or no health coverage to use their identities.

- **Ineffective claims processing methods.** Retrospective claim review frequently fails to recover the majority of money paid. Some payers' in-house FWA detection programs are understaffed and ill equipped to assess suspicious claims. In addition, post-payment (or "pay and chase"), technology can take months to detect and analyze the problem. By this time, payers are less willing to negotiate settlements, and truly criminal organizations may have already changed locations and schemes. Proactive fraud abatement and automated review processes can help payers fight fraud more effectively.

- **A changing landscape of players.** An increase in mergers, acquisitions and consolidation of payer organizations has changed how payers approach FWA, given evolving organizational infrastructure and associated adjustments.

- **Changing ICD-10 Standards.** U.S. providers will soon adopt new global coding standards that may inadvertently open the door for wasteful, innocent errors as well as fraud and abuse. Providers will be required to change their coding systems to reflect new codes for thousands of diseases, symptoms, injuries and abnormal findings, in accordance with the World Health Organization's International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) for diagnosis coding.[3]

[3] From: The World Health Organization, http://www.who.int/classifications/icd/en/

Pre-Payment Benefits for Private Payers

The shift in the federal government's approach - from pay and chase to a pre-payment fraud detection model - is also leading to a procedural shift for private payers. According to the National Health Care Anti-Fraud Association (NHCAA), most of the 70 percent of private payers who use anti-fraud solutions do so retrospectively.[4] Though post-payment has been status quo for many years, recovering funds can be a costly endeavor.

Payers that implement a pre-payment FWA model can use analytic tools to identify potential problems early in the claim life cycle—pre-adjudication or pre-payment—and, thus, catch FWA before paying the claim. Pre-adjudication solutions combine predictive, data-driven analytics, rules-based analytics, integrated code edits, clinical aberrancy rules and provider verification to catch potentially fraudulent or erroneous claims even before claims reach payers.

This prospective approach can help payers:
* Drive down costs from invalid or inappropriate claims
* Reduce payment errors
* Avoid payment delays for claims deemed legitimate
* Improve processes, for more accurate data
* Systematically remove unnecessary costs in the claims process
* Improve capital position by retaining funds earlier in the process

"Gartner believes government mandates emerging from healthcare reform will require a paradigm shift for fraud, waste and abuse detection that will force commercial health insurers to evolve to a pre-payment, pre-adjudication review. This will demand new IT capabilities, an enhanced role for risk management and a profound cultural change among health insurers."

Maureen O'Neil,
Principal Research Analyst, Gartner Research
TICO, Fundeon Offer New Model to Combat
Health Insurance Fraud," April 19, 2010

The following table summarizes the benefits of moving from post-payment analytics to pre-payment analytics.

Post-Payment Analytics	Pre-Payment Analytics
Delayed response to risk results in costly pay and chase	Same-day or real-time analysis helps prevent payers from issuing checks for suspicious or erroneous claims
Requires stable, complete data	Can analyze risk accurately even when data is incomplete
Action is cost-justified only when there is a large financial impact	Action is cost-justified even for small instances of FWA, which become significant as they accumulate
Results in costly legal proceedings against perpetrators	Shapes billing behaviors proactively, reducing the need for legal proceedings

[4] From National Health Care Anti-Fraud Association figures, http://www.nhcaa.org/

FWA management solutions vary in both sophistication and efficacy. However, the most effective programs have many or all of the following characteristics and can:

1. Use data-driven analytics to drive meaningful understanding of patterns, trends and FWA identification in a continuous learning mode
2. Leverage large cross-payer database for more comprehensive FWA analysis, which is especially valuable to regional payers
3. Employ both rules-based and predictive, data-driven analytics for provider profiling
4. Apply clinical code edits with business rules, to reflect and enforce a payer's contracts and payment policies
5. Reduce false positives
6. Employ experienced, highly trained investigators and analysts
7. Facilitate the investigatory workflow by prioritizing outcomes
8. Examine both provider-level and claims-level data

Data-Driven, Predictive Analytics

These analytic-based systems examine patterns and trends to detect outliers. For the best results, payers can deploy predictive analytics *before* payment, either prior to or during adjudication. Unlike rules-based systems, data-driven analytics delve deep into data and find not only known aberrancy, but also unknown and emerging schemes that rules-based analytics may not recognize.

Analytic solutions review hundreds of thousands of data, examining hundreds of variables in various combinations simultaneously to detect unusual fraud patterns that emerge—patterns that were previously unknown. Along with that information, the analytic models provide reasons and contextual information so investigators and analysts can make rapid, informed decisions.

Cross-Payer Data

Payers that manage their own FWA detection see only a very small slice of the (healthcare) world, and are unable to readily identify and prevent claims payment related to new fraud and abuse schemes. Solutions that combine data from multiple sources provide a more complete view of potential FWA.

Aberrancy Rules

As a conduit between clinical edits and FWA-focused predictive analytics, clinical aberrancy rules provide a safety net. Unlike traditional clinical edits or fraud-based rules, aberrancy rules look across multiple data variables and time to determine unusual behavior in the claim. These rules are also able to "count," so an alert is fired only when the claim exceeds a clinically determined threshold. Not only does this provide one more layer to a multi-faceted payment integrity program, it also gives clinical context to the analytics, allowing even more certainty that a claim or provider is aberrant.
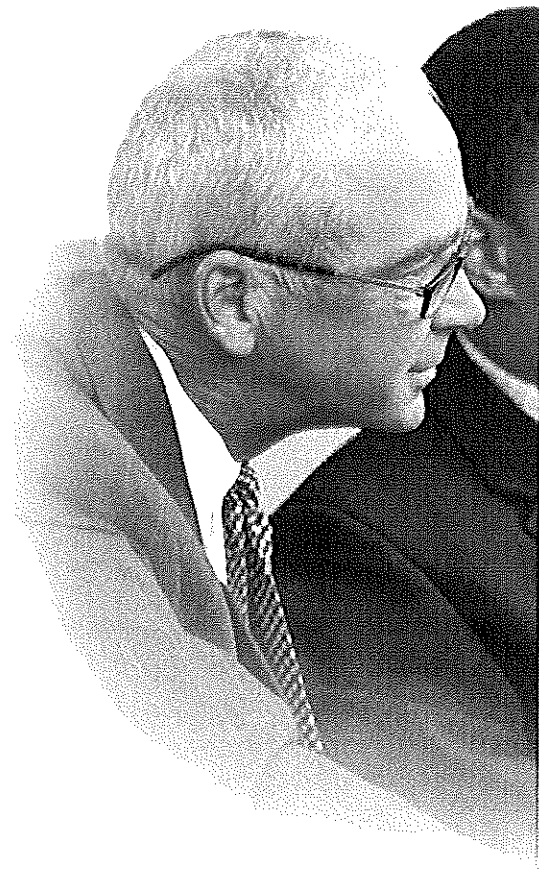
Clinical Code Edits

Most pre-payment systems are rules-based solutions, featuring clinical code screens and edits. These software solutions apply clinical code edits to incoming claims to determine if the claims comply with the payer's payment policy. Using millions of open-source edits to catch aberrations, clinical code edit technology can find coding errors, unbundled treatments, unusual and inconsistent treatment patterns and inappropriate diagnoses. After review, the vendor returns the claims to payers or providers with corrected claim information. Payers can use these solutions pre- or post-adjudication, but always before they pay a claim.

Fewer False Positives

For years, frequent false positives and the time and money spent investigating them made pre-payment analysis undesirable. However, new technologies have significantly decreased both the occurrence of false positives and the subsequent number of manual reviews needed to respond to them. Though a comprehensive solution might identify claims that are not fraudulent, the solution can also point to flaws in provider policies a payer needs to address.

Highly Trained, Experienced Investigators

Knowledgeable, seasoned investigators—with backgrounds in law enforcement, criminal justice, private investigation, claims investigation, statistics and analytics—are often a critical part of finding and stopping true fraud. Expert investigators review and analyze historical claims data, medical records, suspect provider databases and high-risk identification lists while also conducting patient and provider interviews. An outsourced SIU can help recover payments and supplement investigation methods of an existing SIU staff, while an onsite medical director, staff clinicians and certified coders further strengthen the investigatory process.

Prioritized Outcomes

To help payers understand how claim aberrance affects their bottom line, analytic software should score and rank each claim to demonstrate the measure of risk, or aberrancy, it represents. Having a quantified risk analysis for every claim helps payers quickly and efficiently decide how to handle it. Armed with ranked scores backed by explanation, payers can quickly investigate suspicious claims and avoid questionable and perhaps unnecessary payments. Combined with claims amounts, this becomes a powerful tool to prioritize high value items for maximum business benefit.

Claim-Level and Provider-Level Consideration

Every healthcare payer must find the balance between claims adjudication and provider management when assigning valuable company resources. However, using a FWA solution that addresses both areas can significantly improve the effectiveness of each. Sometimes, only during a thorough FWA claims review does it become evident that a provider policy has had unintended consequences. This discovery can give healthcare payers access to powerful tools for provider negotiations.

Successful Integration of a Payment Integrity Solution

The government's increased focus on FWA, along with costly and unnecessary losses, is forcing payers to address FWA management. However, for a new fraud prevention solution to become a company priority and practice, it is critical to:
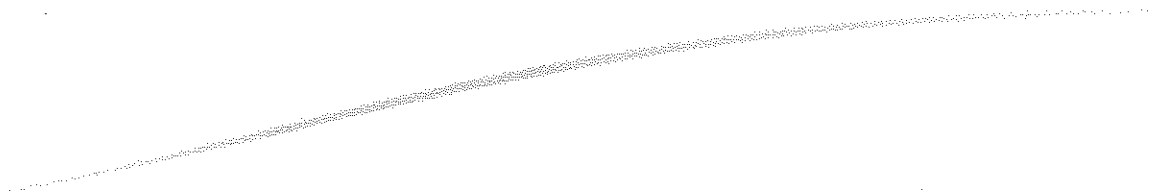
• Prepare and present a compelling business case that demonstrates urgency and offers a solid ROI
• Position the new solution as a valuable new tool for an existing SIU, rather than a source of more work
• Select a vendor that can help an organization meet its business goals and has experience implementing a FWA management solution
• Choose a solution that can compare your data with national norms. Provider practice habits differ across the country.

Executives will likely question initial investments in payment integrity programs, especially if they are operating with lean budgets. Decision-makers must see that the proposed solution can quickly pay for itself.

When building a case for a new payment integrity solution, include the following components:

• The volume of claims processed compared to personnel needed for claims investigations
• The ability to prioritize high-dollar claims that could significantly improve the bottom line
• Examples of FWA from an impact analysis or proof of concept that identify associated costs
• The growing, pervasive nature of FWA
• Annual FWA detection costs, including the cost of internal analytic resources that produce and maintain predictive models, if they're implemented internally
• Potential results of using multi-payer data for better aberrance identification
• How policy changes discovered in anomaly detection can contribute to ROI

To realize the full value of a payment integrity solution, payers must have an adequate and trained staff to manage the solution. As it begins and then continues to detect fraud, a payer can employ additional resources to work toward achieving greater ROI. The technology a payer chooses helps determine what it needs to make the program successful.

Payer operations groups should consider ease of use and training requirements. IT and analytics organizations will need systems and model maintenance. Some vendors offer programs that require a payer to build the analyses using their own tools, which requires IT and analytic staff to build and refine core software. Other solutions offer client-based models delivered with the system that address the costliest FWA.

Since the introduction of a payment integrity solution affects several groups within an organization, it is essential that executive management gain the support and involvement of the SIU, claims, provider relations, finance, legal and administrative departments to successfully move to a pre-payment FWA detection model. Workflows and processes will likely change, but subsequent benefits should become apparent. Internal departments and divisions must embrace the shared goal of achieving effective FWA prevention.

Though payment integrity solutions must include the best and latest technology, vendors must offer the right blend of services and personnel. For fully outsourced payment integrity solutions, payers may need fraud analysts and investigators, certified claim coders and a medical director or other medical personnel. Even when fraud is detected pre-payment, there is always a need for discerning and experienced fraud investigators and analysts, many of whom have uncovered millions of dollars of fraudulent and abusive claims throughout the years.

Emdeon and FICO—a Powerhouse Combination

Emdeon is a leading provider of revenue and payment cycle management, and clinical information exchange solutions, working with more than 1,200 government and commercial healthcare payers and 340,000 healthcare providers nationwide. FICO, serving the top global financial institutions and leading healthcare payers with their anti-fraud services, has developed sophisticated fraud detection and prevention capabilities. FICO and Emdeon have created a unique solution for the payer market, leveraging Emdeon's repository of healthcare claims data and central position in the healthcare workflow with FICO's sophisticated FWA analytics, as well as other data and technical assets. Emdeon's Payment Integrity Solutions with predictive analytics powered by FICO brings a powerful solution set to the healthcare market.

FICO's predictive analytics technology has its roots in the credit card industry, reducing fraud by more than 50 percent for global credit card issuers. FICO's capabilities reduced fraud losses in the U.S. credit card market by two-thirds in a 15-year period, saving card issuers billions of dollars.[5]

Emdeon Payment Integrity Solutions combines Emdeon's vast amount of payer and provider data with FICO's predictive analytic capabilities to produce an advanced FWA management solution that can offer healthcare payers:

- Highly tuned predictive models that can detect new FWA sources
- Prioritization of FWA results, focusing efforts on high value claims
- A fully developed case management system to help investigators fight FWA
- A view into both claims-level and provider-level claims, to maximize results
- Fewer false positives, for greater processor productivity
- Multi-payer data, which may detect new and emerging fraud schemes
- An industry tested solution with market-proven ROI[6]

A comprehensive, versatile payment integrity solution can produce significant results, as it addresses all points in the claim process. The best programs meld rules-based software with predictive analytics, accommodating both pre- and post-payment reviews and audits. As reliable and broad sweeping as technology can be, any well developed FWA solution must also include experienced claims investigators and analysts, who play a key role in identifying aberrant claims and irregularities. Emdeon's Payment Integrity solution meets these criteria.

Emdeon and FICO together provide payers a comprehensive solution to help reduce FWA and improve financial health

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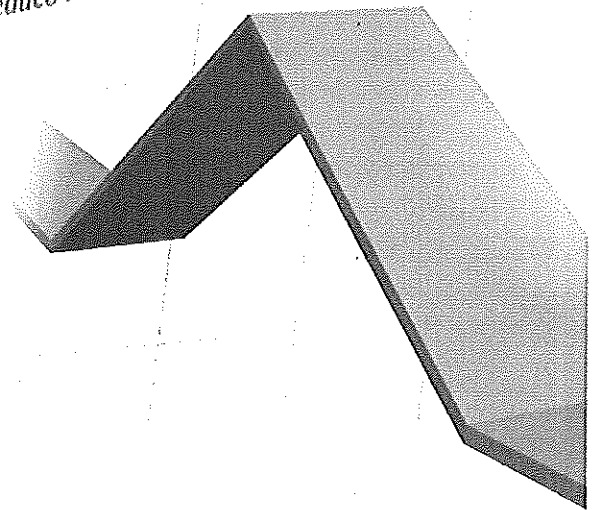
[5] From 'The Nilson Report,' Issue #858, June 2006: "Credit Card Fraud - U.S."

[6] From FICO News Releases http://www.fico.com/en/Company/News/Pages/03-16-2010.aspx

Conclusion

In light of unpredictable economic factors and tight budgets, health insurance companies must continue to search for efficiencies wherever possible. The pay and chase approach to FWA management is largely ineffective, compelling healthcare companies to consider switching to pre-payment solutions to achieve meaningful payment integrity.

Effective pre-payment FWA solutions draw upon multi-payer data and sophisticated analytics. Individual payers—regardless of size—do not have the depth of information gleaned from analyzing multiple payers' claims data. Further, by leveraging the power of predictive analytics to continuously identify new forms of FWA, and by prioritizing suspicious claims for maximum financial benefit and fewer false positives, payers can take tremendous steps toward effectively combating FWA and minimizing lost healthcare dollars.

Ongoing revenue loss often forces payers to impose increased premiums and coverage limitations for patients. Payers that once presumed they could not afford to invest in fraud prevention now realize that market forces and internal financial pressures make critical the need to identify and prevent unnecessary claims payments. Detecting and preventing erroneous claims pre-payment is a strategic way for payers to reduce liabilities and improve their overall financial health.

Combining Emdeon's exceptional connectivity, depth of data and unique position in the healthcare claims workflow with FICO's sophisticated analytics and fraud experience creates a powerful solution. This arrangement is designed to uncover aberrations and anomalies like no other solution available, helping healthcare payers reduce FWA and improve their overall financial health.

Emdeon is a leading provider of revenue and payment cycle management and clinical information exchange solutions, connecting payers, providers and patients in the U.S. healthcare system. To learn more, visit our website at www.emdeon.com.

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